STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297100	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSPECTIVE HOME HEALTH INC	7835 S RAINBOW BLVD SUITE 8 LAS VEGAS, NV 89139

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G 000	INITIAL COMMENTS Surveyor: 22489 This Statement of Deficiencies was generated as a result of the Medicare re-certification survey conducted at your agency from 10/6/09 through 10/9/09, in accordance with 42 CFR Part 484 - Home Health Services. The active census on the first day of the survey was 14. Eleven clinical records were reviewed, including two closed records. Three home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on observation and interview, the agency failed to ensure care was provided in accordance with accepted standards of practice for 1 of 3 patient home visits performed (Patient #3). Findings include:	G 121		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	Continued From page 1 Patient #3 Patient #3 was admitted on 10/7/09 with diagnoses including Pancreatitis, Urinary Tract Infection, and possible Clostridium Difficile. On 10/7/09 at 10:30 AM, a home visit was conducted at Patient #3's home with the Registered Nurse (RN). Upon entering the home, the living room carpet was dirty and had numerous large dark stains on the floor. The living room coffee table was dirty with noted stains. The kitchen floor was also dirty. The RN cleared the coffee table and placed her medical bag on top without using any barrier or cleaning the top of the table. The RN was wearing black jogging style pants. About 1 to 2 inches of the bottom of the pants were touching the floor. With each step the pants bottoms were dragging on the dirty floor or the RN would be stepping on the pants bottoms with the heels of her shoe. On 10/8/09 in the morning, the Director of Nursing confirmed the RN was not wearing proper attire to safeguard against transferring unknown material from one patient home to the another patient home. She also confirmed a barrier should have been used to place the bag on top.	G 121		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits,	G 159		

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G 159	Continued From page 2 prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on interview and record review, the agency failed to cover all diagnoses in the plan of care for 1 of 11 patients (Patient #9). Findings include: Patient #9 Patient #9 was admitted on 12/13/2008 with diagnoses including Diabetes, Edema, Coagulation Defect, and Venous Thrombosis. Patient #9's Plan of Care with a certification period of 12/13/08 to 02/10/09 documented to assess hypo/hyperglycemic reactions, check blood sugar levels with the use of a glucometer, and report blood sugar levels if they were below 60 or greater than 350. There were no blood sugar levels assessed for the entire certification period of 12/13/08 to 2/10/09 for Patient #9. Patient #9's Plan of Care with a certification period dated 4/12/09 to 6/10/09 documented diabetes as one of the diagnoses. There were no orders to assess hyper/hypoglycemic reactions, check blood sugar levels with the use of a glucometer and report blood sugar levels if they	G 159		

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G 159	Continued From page 3 were below 60 or greater than 350. Patient #9's Nursing Assessment form dated 5/2/09 and subsequent visits after 5/2/09 had blood sugar levels being taken and documented. Teaching on hypo/hyperglycemic reactions with the family and instructions when to take blood sugar levels were given by the nurse. There were no orders on the Plan of Care to assess and teach Diabetic issues.	G 159		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on observation, interview, and record review, the agency nurse failed to re-evaluate the patient's nursing needs for 1 of 11 patients (Patient #1). Findings include: Patient #1 Patient #1 was admitted on 6/9/09 with diagnoses including Muscle Weakness, Hypertension, and Hyperthyroidism. Patient #1 was recertified for home care services from 8/8/09 to 10/6/09 for physical therapy services, home health aide services, and skilled nursing services. Skilled nursing services was to continue to monitor vital signs and the patient's medication regimen. There were no changes with the patients blood pressure medications for the	G 172		

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G 172	Continued From page 4 Plan of Care period of 6/9/09 to 8/7/09 and the Plan of Care period for 8/8/09 to 10/6/09. On 10/7/09 in the afternoon, a home visit was conducted at Patient #1's home with the physical therapist. Upon entering the home a blood pressure machine was noted on the patient's dining table. Patient #1 was alert and oriented to person, place, and time. Patient #1 indicated she takes her own blood pressure everyday and as needed. Patient #1 indicated when she does not feel well she can make her own appointments to her physician. The patient indicated she had purchased the blood pressure machine several months ago. The nurse failed to assess that the patient was able to manage her own blood pressure daily and contact her physician when needed. There was no need to recertify the patient for the period of 8/8/09 to 10/6/09 for skilled nursing services.	G 172		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on interview, record review and policy review, the agency failed to assess and measure open wounds on a weekly basis for 2 of 11 patients (Patients #4, #8). Findings include: The agency's policy regarding wound	G 174		

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G 174	Continued From page 5 management dated 1/5/01 revealed wound measurements should be completed weekly. The treatment and condition of the wound should be completed each visit. Patient #4 Patient #4 was admitted on 8/12/2009 withe diagnoses including Diabetes, Cellulitis, Chronic Airway Obstruction, Malaise, and Fatigue. Patient #4's Nursing Assessment form dated 5/25/09 revealed there was a new open wound to Patient#4's left heel and left lateral upper leg. From 5/25/09 to 6/2/09, Nursing Assessments forms for Patient #4 documented treatment performed on the the left heel and left lateral upper leg but no measurements taken. Patient #4's Nursing Assessment form dated 6/3/09 documented treatment performed on the left, right, and left lateral upper leg. There was no measurements taken for all 3 sites. Patient #8 Patient #8 was admitted on 5/1/2007 with diagnoses including Diabetes, Pressure Ulcers, and Neuropathy. Patient #8 had open sores to the left heel and right foot area. There were no wound measurements completed from 6/5/09 to 7/14/09.	G 174		
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must complete a performance review of each home health aide no less frequently than every 12 months.	G 214		

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G 214	Continued From page 6 This STANDARD is not met as evidenced by: Surveyor: 22489 Based on record review, the agency failed to complete 12 month performance review for one home health aide (Employee #1). Findings include: Employee #1's hire date was 4/1/08. There was no recent performance evaluation completed for Employee #1. The last evaluation completed was on 6/2008.	G 214		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on interview and record review, the agency failed to provide written care instructions to the home health aide for 2 of 11 patients (Patients #8, #9). Findings include: Patient #8 and #9 were receiving home health aide services. There was no documented evidence of written care instructions was completed for Patient #8 and #9. On 10/8/09 in the afternoon, the Director of	G 224		

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G 224	Continued From page 7 Nursing could not provide home health aide written care instructions for Patient #8 and #9.	G 224		
G 321	484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on interview and document review, the facility failed to transmit OASIS data on a monthly basis. Findings include: The CMS State Report form obtained on 10/6/09 prior to entering the facility, documented only 2 submissions dated for April 2009 and 1 submission for August 2009. On 10/6/09 in the afternoon, the administrator indicated he was on vacation and confirmed he did not transmit OASIS data on a monthly basis. He indicated that no other staff can transmit the data when he was not available.	G 321		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Surveyor: 22489 Based on interview and record review, the facility	G 337		

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G 337	Continued From page 8 failed to properly review the current dose of coumadin used for 1 of 11 patients (Patient #9). Findings include: Patient #9 Patient #9 was admitted on 12/13/2008 with diagnoses including Diabetes, Edema, Coagulation Defect, and Venous Thrombosis. Patient #9's Medication Profile form dated 6/11/09 revealed Patient #9 was taking Warfarin (Coumadin) 5 mg (milligrams) every day. Patient #9's Nursing Assessment form dated 7/11/09, revealed Patient #9's Coumadin was changed to 5 mg 6 times a week and 7 mg 1 time a week. The Patient's Medication Profile did not reflect the medication change and there was no order obtained from the physician for the changed dosage. Patient #9's Coumadin dosage was changed again on 8/22/09 to 7 mg 3 times a week and 5 mg 4 times a week. The Patient's Medication Profile did not reflect the medication change and there was no order obtained from the physician for the changed dosage.	G 337		